THE BERYL INSTITUTE

Improving the Patient Experience

INTERCONNECTED: An Exploration of Improvement Efforts Connecting Patient Experience and Communication

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About the Academy of Communication in Healthcare

Academy of Communication in Healthcare (ACH) is the professional home for all those who are committed to improving communication and relationships in healthcare.

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About The Beryl Institute

The Beryl Institute is the global community of practice dedicated to improving the patient experience through collaboration and shared knowledge. We define the patient experience as *the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care.*

Effective Communication as the "Must-Have" in Addressing Patient Experience

In the spirit of collaboration on which The Beryl Institute grounds itself, we are proud to present another collaborative effort to reinforce core ideas and push at the boundaries of the conversation on the human experience in healthcare. We have long suggested that at its core, healthcare is about human beings caring for human beings. Caring requires connection relationship and the core activities that frame the very definition of patient experience itself – *interactions*. The interactions we have in healthcare are vital, and our work and other research continues to show that when we get interactions "right", we ensure the best in experience overall. Those interactions are shaped in large part through the art of communication. It is why I suggest effective communication is a"must-have" in addressing patient experience.

This paper, co-authored by our colleagues at the Academy of Communication in Healthcare, and the inquiry it shares into the communication issues and opportunities we must continuously work to address in healthcare today, serve to reinforce much of which we know in heart and mind, but too often lose in practice and action. The discoveries shared here remind us that we cannot and must not allow that to happen. When we ask people what matters to them in healthcare more often than not they mention communication elements such as: how they are treated, how they are listened to, how things are explained, and how dignity and respect is conveyed and needs determined. These elements all require a commitment to effective communication, not as a complex process or protocol, but rather as the fundamental essence of our commitment as human beings caring for other human beings.

In the 2017 State of Patient Experience research conducted by The Beryl Institute, we saw that when asking organizations their top area of focus or action in addressing patient experience, that communication again rose to the top. This was not just in the broader concept of communication itself, but in all the ways in which communication manifests itself in organizational life. The top item identified – rounding – is itself a structured tool for effective communication. The areas that were revealed to be growing most quickly in terms of priority – a combination of employee and patient and family engagement – are also grounded in our capacity to communicate. We must avoid the temptation to view communication as a singular idea, but rather, we should view communicatin as a means by which we support many of our actions and ultimately realize many of our results. It is for this reason the this paper provides practical value to all who are seek to strengthen the communication "muscle" we must constantly "work-out" in our healthcare organizations today.

We were fortunate at the end of 2017 to release another collaborative paper with the American Association for Physician Leadership entitled *Connected*. In our exploration of the broader question of what impacted the relationship between physician and patient, the idea that rose to the top here, too, was communication. What we shared in concluding that paper was "In the end, physicians want only to communicate, inform and educate patients in ways they can fully understand so that decisions can be reached that meet their individual health care goals. And the patients who rely on their physicians want the same thing." This mutual understanding of not only the need to communicate, but the impact it ultimately has, returns us to the essence of this paper.

When we acknowledge the central role communication plays in our capacity to effectively deliver every aspect of care in healthcare and that it is the interactions driven by that ability to communicate that drives the experience people have in healthcare, we underline a simple, but powerful call to action. In committing to ensure the best in outcomes for those delivering care or looking to achieve the best in outcomes from those receiving it, requires we focus on not just the science of communication but its art.

We must be called to reflect, evaluate and act on how effective we are in our communication processes, reinforce our weaknesses and elevate our strengths all with the greater intention of positively impacting the patient, family and caregiver experience – the human experience in healthcare. The inquiry here helps us to further consider what it will take and the opportunities we have to improve. These are opportunities for all in healthcare that we cannot afford to miss.

Jason A. Wolf, PhD, CPXP
President
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Guest Commentary

Last week, as I was starting on inpatient service, the team was struggling with Mr. A, who had been admitted three days prior. He had spontaneously lost consciousness and fell on his face, sustaining a mild fracture of a facial bone. Though typically an overnight admission, Mr. A had hung on for what was now his fourth day in the hospital. Initially, the team felt they had shown great compassion to Mr. A, but on each successive day, they had become increasingly frustrated with his lengthening list of concerns, begging the team to wait "just one more day" for discharge, then raising even more concerns that he felt should keep him in the hospital. The hospital's utilization review board made strong recommendations based on evaluations by cardiology, facial surgery, and physical therapy, there was no indication for prolonging the inpatient stay. As a result, the team felt that a mutually agreeable discharge was impossible and therefore was eager to see how I, as a "communication expert" (an appellation that is impossible to live down), would handle the situation.

Though we all know that it is the right thing to communicate effectively and compassionately, sometimes it is challenging to follow through. Cases such as Mr. A's cause strong reactions for all involved. They are emotionally upsetting. They are not easily resolved by clinicians' usual approach to handling conflict – biomedical explanations to the patient. They can call into question clinicians' expertise. They insinuate themselves into our heads, and we bring them home with us, where they can cause us to worry, lose sleep, resort to unhealthy behaviors or substances, or in some cases lash out at our loved ones. Of course, none of those methods of coping make us feel very much better.

Effective use of fundamental communication skills directly addresses important patient experience metrics, such as listening, treating with courtesy and respect, and explaining things in a way that patients can understand. Over the past quarter-century or so, patient-clinician communication has become a prominent field of scientific research. Important findings from these data affect almost every interaction we have in healthcare. Effective communication leads to improved outcomes in specific diseases, including coronary artery disease, diabetes, hypertension, and HIV, among others. Unfortunately, clinicians do not communicate as effectively as they think, in part due to systemic factors, but also due to a lack of training in fundamental communication skills. Yet burgeoning evidence demonstrates that training in these skills not only helps patient experience scores but also increases clinician empathy and decreases clinician burnout. It is a win for patients, a win for clinicians and staff, and a win for institutions.

At this point, it may seem a quick fix to advocate for adoption of communication skills training across the board. But it's much easier said than done. If you have ever tried to improve your skills in a sport, a musical instrument, or a highly technical procedure, you know that it is far from enough to hear a one-hour lecture about any of those and expect that as a result you will become develop expertise. Communication skills are equally complex and similarly require ongoing practice with feedback. Many clinicians do develop effective methods over a long career of trial and error. But our patients deserve better than that. There are specific evidence-based methods that reliably help define the scope of clinical encounters, elicit patients' perspectives, develop connections with empathy and compassion, and check for patients' understanding of clinical treatments. And what's even better: everyone in healthcare can adapt many of these same skills to have more effective conversations with patients as well as with colleagues, team members, staff, supervisors and leaders. These are not just patient skills or provider skills: they're people skills.

With Mr. A, I greeted him warmly and introduced myself and the team members accompanying me. I sat down and elicited the full list of his concerns. It was not endless: there were eight items. I then asked him where he felt the endpoint of his hospitalization would be in his estimation; he could not say, but he asked for one more day to see how he felt the next day. But rather than refuting his request immediately, I ventured to ask if he was scared that he could faint again – was this a reason he didn't want to leave? He said, "Not scared. Concerned."

I said that the team definitely shared his concern, and thanked him for letting us know. I expressed happiness that we had addressed some of his worries, reassurance that we could quickly complete everything we could still do, and finally sorrow that we could not finish every item on his list. He seemed a bit less agitated and reiterated his wish to stay in

house one more day.

I responded with, "I really wish we could make you completely better right now. It will take time for you to recover. Unfortunately, staying one more day is not negotiable."

He merely shrugged his shoulders a bit and said, "OK."

I asked what other questions he had. He said, "None. Thank you for everything you've done."

I know you are remembering interactions with a higher degree of difficulty than this one. I must say that I too was expecting more resistance, and I was prepared with more communication tools than I ended up using. But the lesson that reinforces every time I use this approach effectively is that the great majority of people, even those who may be billed as "difficult," respond to authentic connection with these relationship-centered skills. The additional good news is that nearly everyone can learn them.

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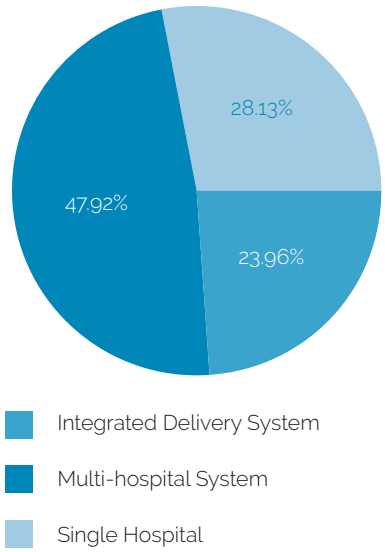
Purpose and Methodology

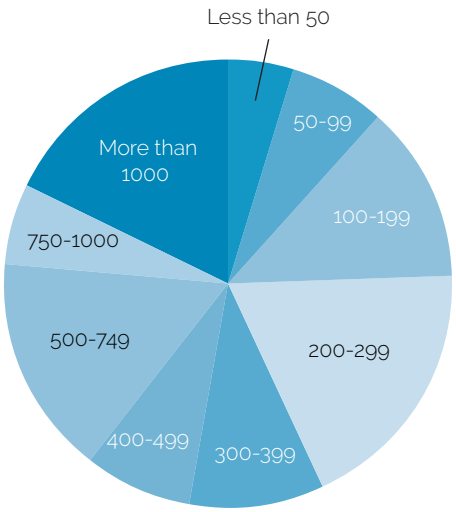
The intention of this study was to explore the state of interpersonal communication practices in relationship to the patient experience outcomes in U.S. healthcare organizations. In doing so, we looked to understand the present state of communication effectiveness within the patient experience context for doctors, nurses and teams, to identify perceived barriers to optimal communication with both patients/families and colleagues/teams and to evaluate the success of efforts to address communication deficiencies.

Initial data was collected via an online survey conducted in late 2017 with 112 respondents from U.S.-based organizations, 65% in urban geographic settings and 35% in rural. Almost half (46%) of respondents represented multi-hospital systems, with the remaining coming from single hospitals (28%) and integrated delivery systems (23%).

Organization Type



Number of Hospital Beds



Number of beds at participating organizations varied, with representation ranging from under 50 to over 1,000 and at every increment between. Seventy-three percent of organizations identified themselves a not-for-profit while 16% were for profit and 11% were academic medical centers. Over half of organizations were teaching hospitals.

To gain a deeper understanding of challenges and drivers of improving communication, survey respondents identifying communication as a high or very high priority for their organization were invited to participate in a phone interview with a member of The Beryl Institute staff. Ten phone interviews were conducted, providing further insights on this research. Excerpts from those interviews will be included throughout this paper in hopes that sharing the direct experiences and lessons learned from these organizations will inform and inspire others in their patient experience efforts.

Communication as a Priority

When asked to rate the current level of priority their organization has placed on improving communication as part of its patient experience effort, 38% identified it as 'very high' and 45% as 'high' while 5% and 1% identified it as 'low' or 'very low,' respectively.

Of those citing 'high priority,' many linked the effort with an overall organizational culture transformation and/or response to patient or family feedback. Several respondents also noted an integrated view of quality, safety and patient experience and the critical role communication plays in each. However, the most frequently identified driver was the acknowledgement of the financial impact of reimbursements based on HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) ratings. While HCAHPS was frequently identified as a driver based on financial implications, several respondents shared HCAHPS data revealed communication was more of a challenge than their organization had previously realized, highlighting a need that led to a focus on improving communication.

Organizations rating the priority level as 'low' cited other organizational focuses taking precedence such as the development of an overall strategic focus on patient experience that will later lead to communication improvement efforts. Several competing priorities were also mentioned such as addressing health disparities, patient access and scheduling.

Evaluating Healthcare Communication

The advent of value-based care has prompted increased scrutiny of every aspect of care, including healthcare communication. Contributors used a wide assortment of tools to assess the quality of clinician communication within their organizations. Traditional measures such as HCAHP survey scores, patient satisfaction surveys and online physician ratings were commonly cited, but contributors also solicited feedback from Patient and Family Advisory Councils (PFACs), employee engagement surveys, occurrence reporting and by personally consulting patients and associates to identify opportunities for quality improvement.

We asked contributors to share the ways their organizations measure or assess successful communication. In addition to the measures mentioned, contributors also shared additional means for capturing feedback and reflections on the importance of collecting and understanding patient experience data.

> *Our state of patient/clinician communication is in a continuous improvement loop. We use the lessons learned from many areas to better understand the opportunities, from subjective survey data that represents perceptions, all the way to objective measures of reducing harm, which we would consider another proxy for good communication. Examples include no readmissions for the same issue, no visiting the ED for the same issue, zero unexpected deaths, length of stay and patient satisfaction.*

> *One of the ways that we measure successful communication is by what we call 'good catches' or occurrence reporting. We look at occurrence reporting not as punitive at any stretch but to uncover ways we can improve processes, communication, what's working well and what's not working well. Our associates take ownership and use our occurrence reporting as a good catch method. We had an assessment recently by our corporate communication team. They assist us in assessing how often newsletters are read and how often or how valuable they are. They're evaluating that now to see if there are other opportunities in which we can be more successful with communication.*

One contributor described an evolution of communication measurement occurring over a short time period as the organization began to better recognize opportunities to assess and address communication challenges.

I think of how we measure or assess it today and where we want to go to measure and assess it in the future. Previously, it was focused on the HCAHPS questions, the communications domain. That was how they measured the success of communication between providers and patients. We've expanded it now to go beyond just what's in HCAHPS. We look at TeamSTEPPS and metrics around TeamSTEPPS, so we branched communication from just communication with patients to communication with each other. Even with that, it's difficult to rely on a number, because communication is so dynamic. We are starting to really look, measure and assess: What are the materials that we're giving to patients? What are they seeing on our website? What are the messages that are going out from the staff? After interviewing patients to gain their perspective, we include that in our measurement of successful communication. We are not just looking at the data but creating a much more well-rounded picture of that.

Another institution implemented a system of rounding on associate leaders to solicit feedback about departmental needs and provide support as needed:

We really go to the associates and find out what's working well because up in the C-suite we can make assumptions that things are already working well. But unless we get down onto the floor, those are the ones who are driving the care and driving patient experience. And that way it allows our associates to get a closed loop communication. So if something wasn't working well or they needed equipment, or they asked for a change in process, whether it was done, or it couldn't be done, is then close looped in that rounding. And it allows our associates to always feel like their voice is being heard.

Measurement strategies were tailored to address the unique needs of each institution and targeted stakeholder groups.

Challenges in Healthcare Communication

The relentless pace of medicine can leave clinicians struggling to balance all aspects of patient care. Time constraints, high patient volumes and competing priorities all contribute to a cognitive burden that often compromises clinicians' ability to mindfully attend to patients during interactions. Multi-tasking physicians report "near misses" in electronic health record documentation and in patient communication.1 Distracted physicians miss valuable opportunities to express empathy, fail to detect important patient cues and may not recognize opportunities to build rapport. Despite many competing demands, clinicians desire more quality time with patients. The reality, however, is that clinicians have less time to consult with patients, and care delivery has become increasingly complex. As healthcare leaders seek to improve patient satisfaction in their organizations, communication is increasingly perceived as an integral component of patient care. When we asked contributors to share the most significant communication challenges at their institutions, they described numerous barriers.

Of chief importance was the need for clinicians to clearly convey information to patients in a manner easily comprehended while inviting clarifying feedback:

Patients may not have good numeric literacy or health literacy. Getting the health information that the clinician wants to convey to the patient in a way that allows them to form an effective partnership is lacking.

I'd say the most significant communication challenges that we face is explaining things in a way that our patients can understand, receiving feedback in the form of a teach back from our patients and ensuring that we are communicating clearly.

Our greatest opportunity for physicians is explaining things in a way that our patients can understand.

We give them the information. We assume they understand it. We ask, "Any questions? No? Okay, great." And then we're off to the next thing. And that's not because they don't care and it's not because they don't want to be sure. I think for many of them it's a time thing and the assumption that 'If I said it, then they heard it and understood it'.

Organizational communication, such as departmental handoffs, were also cited as a communication challenge, especially for clinicians contending with competing priorities and limited time. Our contributors stressed the importance of adhering to these communication processes, as well as the consequences for patient safety.

> *The biggest communication issue we have is probably department to department, handoffs of patients. Patients don't just stay in their room the whole time. They're out for tests, there are multiple caregivers coming in and that handoff is one of the biggest challenges. Everybody is so task-focused, so strained, and pulled in so many different directions that they forget the importance of taking the time to stop and have that communication.*

> *It's not about "How does my patient know if I've done their c*ardiac cap correctly?" It's about the communication and safety.

As clinicians grappled with providing care in busy and often stressful contexts, contributors observed that key relationship-building communication skills, including listening and expressing empathy, were absent:

> *Our hospitalists are feeling a lot of pressure to ensure that they see the number of patients they need to in a timely fashion. And yes, we do receive the, "I just don't have time to sit and listen," or, "I don't have time to sit and do the human business, human model." We're trying to re-engage them differently to let them know that doing that sitting, listening and showing empathy will save them time.*

> *Listening is a key point. Just being present. We know how busy they are, it's not only the higher acuity of patients, but the fact that clinical documentation takes so much more time. They feel pressured to stay on the move which creates situations where they are not really present for their patients' conversations.*

> *Listening is just not good. That is something I'm constantly astonished by when I round. We'll step out of the room and I'll say, "Gosh, I was really concerned when I heard Mrs. Smith say that she doesn't have a ride home and that there's no one she can depend on. You're talking about sending her home, but she's needing complex care and some additional assistance, and home health is only going to do so much." That was literally a conversation from this week, and the physician said, "I didn't hear that." So we went back in the room and then we walked out, and he said, "Wow, you're right".*

Perceived Barriers to Effective Communication for Clinicians

Through our research we sought to learn more about potential barriers in physician and nurse communication in hopes of uncovering challenges that might also lead to potential solutions. Survey respondents consistently identified skills such as explaining things in a manner the patient understands and listening as key deficits. Closely related, however, were administrative challenges such as high case load, frequent staff turnover and time constraints.

Physician Communication

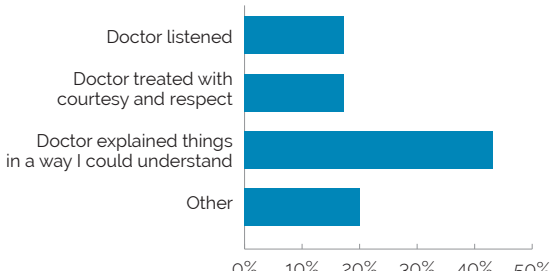
While reflecting on physician communication challenges, contributors described organizational stressors such as high patient volume and time constraints that led to clinician burnout and complicated efforts to create and sustain patient experience values in organizational culture. Contributors found it challenging to convey to their clinicians the positive effects of relationship-centered skill building during the clinical interaction, as well as the proven effects on patient health outcomes. Contributors often had trouble finding time to address communication related issues and experienced clinician resistance to coaching and/or feedback attempts. Lack of clinician and leadership buy-in for patient experience and/or communication training initiatives emerged as common themes:

> *One of the most significant challenges is in the actual training of a good communication skill system. And taking the time. We roll out a lot of patient experience training, and physicians, when they do come, are often not truly engaged in the education. I think there's a little bit of ego involved where they think they already know all of this stuff. So, that poses one barrier, one challenge with it. And then just getting everyone on the same page so that we're all talking the same style. We're all using the same tools. That sort of thing.*

> *In my specific line of work, it is challenging to me to train doctors about improving communication because it takes time to practice effective communication. Ultimately, mastering certain skills would save time, but the investment of time is very difficult for a physician to choose to make. Buy-in is critical.*

Aspect of Doctor Communication Most Challenging in Current Patient Experience Efforts

Please indicate the aspect of doctor communications that is most challenging in your current patient experience efforts:



> *We are partnering with our affiliate health system to send some of our physicians to a two-day communication skills train-the-trainer program. They attend but have no interest in cascading the training to other on-site physicians.*

The concern of very little buy-in from the top was also reflected in open-ended comments shared in our online survey:

> *Doctor buy-in: Many still feel they are really good at what they do, being a doctor, but don't think the things that seem like "fluff" truly have an impact on outcomes.*

> *Doctors don't have buy-in. Can't get most of them engaged.*

Leaders also expressed concern over contracted hospitalists and physician groups with little investment in the organization's patient experience objectives or goals:

> *We have physician groups that come in. They develop no relationships with staff or patients. They come and go.*

> *Holding physicians accountable…oversight for the physician groups that have the greatest impact on these scores.*

One contributor shared the simple need to be more mindful of where conversations are happening within the organization.

> *A challenging area for us has been staff having conversations where they shouldn't be having them. I always think of on-stage, off-stage, and sometimes just given the busy-ness of things, we have some of those off-stage conversations on-stage, where patients and families can overhear them.*

And the importance of listening and providing comprehensible, digestible communication emerged as a shared concern:

> *Taking time to listen and deliver the message in the format the patient can understand and incorporate into their life.*

> *Challenges are convincing patients that listening and explaining things clearly to patients impacts clinical outcomes and their (physicians) interpersonal skills matter a lot to their patients.*

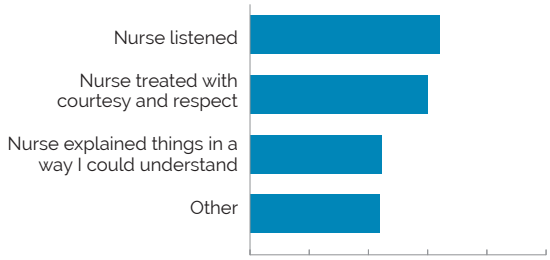
> *A big hurdle is around health literacy. We need to recognize and simplify the materials and the communication that we have with patients. We're sending them home sooner. We're asking them to take care of themselves. They're going home post-op day one, and we're telling them to change their dressings and really important things for their care, yet we aren't communicating in a way that they understand, or at a grade level they understand, or in a language they understand. That takes reviewing every form of communication we have with patients, to make sure that it makes sense in the eyes of the patient. Because to us, it makes sense, because there's so many people that have been trained in it, but patients don't see it that way.*

As one contributor articulated, it's a change in mindset for some physicians:

> *This is not about making our patients happy. It's about the interaction between their experience and their safety. It's safety here within the hospital with communication and safety going home with communication. Have we communicated why they're taking their medications? How often they're taking their medications?*

Aspect of Nurse Communication Most Challenging in Current Patient Experience Efforts

Please indicate the aspect of nurse communication that is most challenging in your current patient experience efforts:



Nurse Communication

Staffing challenges and time constraints emerged strongly as contributing factors to nurse communication. Taken together, these factors are inter-related and create an environment in which priority may not be given to the delivery of communication.

> *Staffing issues: Units are always short-staffed and overworked causing shorter attention spans and understanding.*

> *Staffing patterns make it extremely difficult to spend time with patients and be able to truly listen.*

> *Evolving organizational culture where nursing turnover is high, and they feel like they are not valued.*

Contributors further explained that nurses struggled with high case loads and did not perceive patient experience skills as having high priority during time constraints:

> *Every one of them thinks they're doing a great job at this and the surveys don't truly represent how things really are. When pushed, the response is, "We are too busy trying to save your life to worry about how courteous we are."*

> *The amount of time a nurse has at the bedside is limited due to patient load, making a connection with patients sometimes difficult.*

> *Staff say they don't have time. They say they are too busy.*

> *There is a mindset that they can't afford empathy and are too busy to be nice.*

Impact of Culture/Diversity on Organizational Communication Outcomes

When asked to rate the level of impact that culture/diversity is having on their organizational communication outcomes, 66% identified it as 'high' or 'very high.' Respondents reported opportunities for growth in developing communication skills and competencies to support diversity within their surrounding communities. Participants explained that in many cases their institutions were in diverse communities characterized by limited English proficiency and highly variable education levels. Within these contexts, it is clear clinicians must be equipped with cultural humility and the ability to discern and deliver health information that addresses the unique needs of each patient. Communication skills training and coaching were recommended as solutions for equipping clinicians with the skills needed to address these needs.

> *We serve PhD's and their families and we serve people from very rural, very poor communities and so you watch clinicians have to pivot between the communication needs of these two very different populations. And the importance of the information that the clinician wants to convey across to the patient in a way that allows them to form an effective partnership is lacking.*

> *Certainly, we've got plenty of folks on staff who are bilingual and can help with the translation, but in terms of just cultural issues or specific things that we would just need to know to care better for our patients, I think there's probably some opportunity there.*

> *I would recommend coaching, and if money weren't an obstacle, coaching staff one-on-one. Putting everybody through diversity training and then following up with coaching. How's it going? Where are the struggles? Shadowing and inviting feedback. I think that would be my ultimate approach, if I was queen for the day and money was not a concern.*

Overall, providing care for non-English speakers and patients with low health literacy consistently emerged as a concern for our contributors. As one commented, *"...It's just a big, big, big challenge. I think it's probably a challenge for everybody."*

Another contributor explained:

> *English as a second language is likely one of the most significant challenges we face. The institution and Patient Services have addressed this head on and worked very hard to make sure that our employees who are going to be doing any interpreting are certified and it is reflected on their visible badge. Someone who may speak the same language as the patient's language of origin is not necessarily the appropriate choice for an interpreter. So it's a constant area of focus to make sure that although we use each other to help with our team communications and patients, we find someone who's been trained, has taken an exam and is certified to be pulled into the room if it's determined an interpreter is needed.*

Identifying Communication Solutions

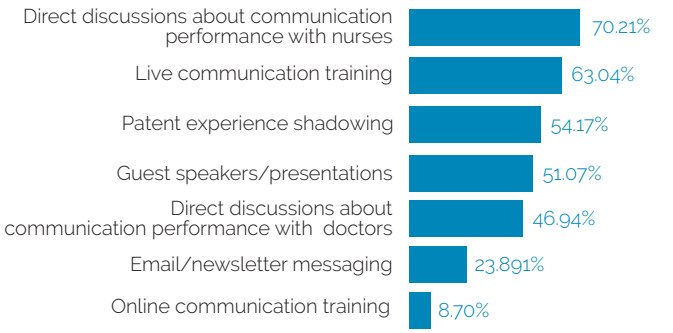
Contributors discussed the advantages and disadvantages of a number of different communication training methods, including direct discussions, shadowing/coaching, guest speaker/presentations, newsletters/messaging, online training and in-person training. While these results do not reflect all available communication training methods, contributors' feedback suggests certain approaches may be more effective for clinicians than for staff.

Most Effective Communication Training Methods

When we surveyed about the effectiveness of various communication training methods, survey respondents identified direct communication, patient experience shadowing and live communication training to be "effective" or "very effective." When we further inquired about the effectiveness of these methods with contributor interviewees, live in-person communication training (including patient experience shadowing, direct discussions with clinicians and in-person communication training programs) strongly emerged as one of the most effective training methods.

Communication Training Methods

Percentage of respondents identifying methods as "effective" or "very effective."



In-Person Communication Training Approaches

Communication course offerings described by our contributors varied from a one-day fundamental course to ongoing education, including train-the-trainer programs.

Patient Experience Shadowing, Coaching and Direct Discussion: Coaches and/or mentors typically observe clinicians during clinical interactions. Shadowing is often followed by coaching with guided feedback.

> *For the communication itself, an ideal approach would be more of a coaching relationship where we had more than one coach and they are out everywhere giving just-in-time feedback on how someone is coming across or how they're being perceived or even ways that they could be perceived differently. That would be my ideal approach. I'm a big believer in live, in-person interventions.*

> *I think my goal in 2018, maybe even 2019, is getting a robust patient and family advisory council established, people who can come in and tell you from the patient's or the family member's perspective and work directly with our clinicians and providers here in a role playing scenario and just give them a real world idea of what it's like to be a family member, something that physician might say that they think is a wonderful thing to say might be taken very differently through the*

ears of an actual patient or a family member. And getting that kind of feedback is so powerful. It's one thing to have me as the Patient Experience person try and coach, but it takes on a whole different meaning and level of gravity when an actual patient says, "I know you think that that's a great thing to say, but really, that's not how we hear it. What I hear you say is this."

We really do prefer the live, in-person coaching. I think it really makes it much more personal and it offers more opportunity for questions and very specific feedback. When I'm going out and shadowing some physicians here, I know I prefer that kind of in-the-moment feedback. I prefer the in-the-moment feedback for our providers, and I think they do, as well. I think something as personal as communication styles is harder to do online or via distance learning. To me it seems like coaching is something that has to be done live and in person, playing it out right then and there.

In-Person Communication Training Courses

So as it happens, we are in talks right now with the Academy of Communication in Healthcare … We're certainly getting very close to signing and really using the train the trainer model to start with a select group of physicians here who will be our initial cohort and undergo all the hours that are required to be able to teach the next group, who then will be able to teach the next group and the next group and the next group. And we're really excited about that. We're looking to get that started in early 2018. And we hope that that will really get the ball rolling when it comes to effective communication strategies. And our team here, the initial group, is really excited to be part of that group. They want to take a more active role in mentoring and coaching others here instead of having completely just an outside organization coming in and doing the training. I think it starts there. Certainly, we're going to engage their help, but then have the snowball effect come from our internal designated leaders and the informal leaders, people who are well respected across the facility, across the system.

Overall, leaders found that in-person training, especially with the use of role play and when conducted in small groups, was the most effective form of communication training:

Most effective are when we can do the smaller group huddles or department meetings instead of when we have our core competency sessions for our entire organization, which means that the minimum that would attend is around 100 people. So, it's much more open when we can do it in a smaller format so that people aren't afraid to ask questions and can role play.

Our ideal environment for training is definitely in-person. We have asked people their preferences and over 70% of our workforce prefers face-to-face opportunities.

I would say that in person training really does help and has been most effective because you have opportunity for dialogue during that education and training. You have the opportunity to tell stories. You have the opportunity to review case studies and patient comments and scores, and that really helps synergize not only speaking to the data and here's what we need to do, but it really helps build that relationship and speaks to the heart and that's important.

We've talked about how we can use computer-based learning to follow up and simulations to follow up with the sustainability portion of our training. But I think that starting with live, in-person training at first was so important. I think it turned a lot of people around hearing what others were going through by sharing their stories and moments.

We do live, in-person trainings, role playing, one-on-one training, group session trainings and online virtual training courses. With hourly associates, I feel that the actual live, in-person, one-on-one training and role playing are more valuable and beneficial for them. Many of our team members do not have high school diplomas, and we also have some that are completely illiterate.

Other Communication Solutions

During interviews, our contributors described other training methods such as online curricula and training videos, that were helpful for sustainment but most effective when paired with in-person communication training opportunities.

Online Communication Training: Online or distance learning that delivers communication skills training, often with assessment tools or "quizzes" following each module.

Our contributors noted that, while effective, this methodology was most often effective when paired with another form of training.

> *We do have intranet training and it really is just a checklist for most people. I have talked with several people about it, and they don't even watch the modules. They just go in and try and take the test. If they fail, then they go back in, zip through it really quickly and re-take it. So unless there's a really big vested interest in learning what the information is, it's just a checklist for most. I think that's where live, in-person interventions can make it more real for people.*

> *I think it's harder to do some of that online or via distance type learning. To me it seems like it's really something that has to be done live and in-person and playing it out right then and there. Scenarios that you might see online or things that you can do theoretically are fine, but we don't practice theoretically. We practice in-person. And you've got people who are in the room, whether they're actors we hire or role playing or whether we're just talking about a real life situation that you encountered, I think it's important to have that live, in person, in-the-moment training. That's how we prefer it.*

> *We'd all sit there and go "Enter, enter, enter." "Okay, who has the answers to the test?" Good, bad, or indifferent, it's like you try to get them done while you're at work. And we're squeezing it in between care times - and who wants to come to work on their day off - even if you get paid for it?*

Yet another contributor noted that online communication was most effective when coupled with in-person training:

> *Doing a partial online program for knowledge-based learning needs to be coupled with classroom time for developing and applying skills in a smaller group setting. It can help reduce the amount of time providers are in the classroom so they can apply the needed skills in interpersonal communication, such as conflict resolution, for instance.*

Videos: Informational videos that demonstrate fundamental communication skills training were also mentioned as valuable resources by some of our survey respondents.

A contributor described the merits of communication training videos when paired with in-person training:

> *We show some good videos about what might be going through a patient's mind and then do some role playing. Cleveland Clinic has that excellent video where it shows what is going through people's minds. If you have access to excellent videos like the Cleveland Clinic video, then video training and in-person together would be best options, I think.*

Contributors' emphatic endorsements of in-person training methods echo much of what we find in research about communication education for clinicians. As an example, research has found that communication trainings are most effective when they are learning-centered, focused on practicing skills, and lasting at least one day. The best strategies within these programs include role-play, direct feedback and small group discussion.3 Our contributors described a number of approaches to delivering in-person training and also expressed a preference for those trainings that provided immediate feedback and the opportunity for real-time practice of communication skills needed during real interactions with patients.

Considerations for Action

This paper has explored the state of communication efforts in U.S. hospitals through the experiences and reflections of our survey respondents and contributors. While these insights are certainly not indicative of the efforts of every organization, we believe the sample provides high-level data that can help acknowledge the progress and frame the opportunities for many.

In closing, we offer a summary of considerations reinforced through this research and supported by the mission of the Academy of Communication in Healthcare (see page 19).

As healthcare organizations seek to drive positive patient, family, staff and caregiver experience through communication improvements, we offer these five key recommendations:

Assess your current state

As with any improvement effort, a key first step is to establish a baseline specific to your organization. Through a combination of measurement and feedback efforts such as patient and employee satisfaction surveys, patient/family/employee focus or advisory groups, real time feedback programs and other means, create a transparent internal assessment of your strengths and opportunities. Several of our contributors noted their organizations *thought* they exceled at communication efforts until measurement tactics highlighted areas where improvement was needed.

Acknowledge areas for improvement

After assessing your current state, acknowledge and document your key opportunities for improvement as they apply collectively to the organization as well to any specific roles or departments. Remember that the purpose of assessing is to identify gaps and drive change, as it can be counter-productive to use your findings in an approach that punishes or embarrasses team members.

Prioritize your opportunities and share your findings and recommendations with senior leadership to help establish organizational support for your improvement efforts.

Ensure focus on cultural competency/diversity

Comprehensive efforts to improve communication must include a strategy for all populations you serve. As we shared through the research, two-thirds of survey respondents rated the level of impact culture/diversity has on their organizational communication outcomes, as 'high' or 'very high.' The need for sensitivity and clear communication to all holds true in every clinical and non-clinical interaction.

Identify tools to support your efforts

We were reminded through the experiences of our contributors that relationship skills, communication skills and teaching skills are learnable and teachable. As you uncover opportunity areas, explore the landscape of available programs to support your improvement efforts. Many customizable resources are available in the healthcare marketplace that can expedite your training and development programs through access to evidence-based methodologies and expertise from industry thought leaders.

Continually re-assess to build and sustain efforts

While establishing a foundation for communication excellence is a critical step that can establish expectations, support development and help ensure you are headed down a positive path in improving patient experience, this focus must be more than a one and done initiative. Consider how you will sustain efforts with current employees and how you incorporate new team members into the culture. An ongoing focus and investment in the quality of relationships and communication can have an exponential impact on the experiences of your patients and team members.

While our primary intention through this paper was to share the current state of communication efforts, we hope the stories and experiences presented assist others in building communication programs that positively impact the human experience that is the core of healthcare. As articulated in the work of The Academy of Communication in Healthcare, improved relationships and communication enhance team and patient satisfaction, reduce errors and grievances, improve efficacy, efficiency and safety and enhance overall health outcomes[3]

Guiding Principles for Leading Organizational Culture Change[4]

Institutional leaders must not only invest in developing and maintaining the communication skills of clinicians and staff across the organization, they must also consider key strategic planning elements prior to embarking on the actual change efforts. Based on knowledge accrued while leading communication improvement efforts across a variety of healthcare organizations, The Academy of Communication in Healthcare outlines the following basic guiding principles using the Kotter model for leading organizational culture change:

a. Creation of a sense of urgency: We encourage patient experience leaders to "build a case" regarding the local state of communication within their organization, based on various data points. Creating a sense of urgency requires clear articulation of the forces that presumably led up to the formation of this group, including efforts to identify and address potential crises and opportunities.

b. Formation of a powerful guiding coalition: We recommend the development of a communication steering committee, formed by thoughtful leaders who represent key stakeholder groups from across the organization. Additionally, the establishing a group of communication champions or trainers can serve as role models and teachers. These representatives ensure that the institutional commitment is strong enough to support a culture shift reflective of improved communication behaviors.

c. Creation of vision: We provide the following example of a generalizable and powerful vision statement *"every member of the healthcare team, from executive leaders to physicians to administrative staff, will employ the best in healthcare communication skills, both with patients as well as with colleagues, and will endorse the value of treating patients as fully collaborative partners in their care".*

d. Communication of vision: We recognize the importance of a full endorsement by the senior executive team as absolutely critical, both to reinforce long-term commitment to the program and to facilitate the removal of common barriers as effective communication is embedded into accountability measures, such as the performance review process.

e. Creation of short-term wins: \ A small-scale initial intervention rollout can demonstrate quick return on investment. Consolidating improvements and producing more change involves increasing word of mouth and disseminating successes. For example, The Academy of Communication in Healthcare has found that a vast majority of participants who attend workshops around communication skill development have not only reacted positively to trainings, but they also experience a renewed sense of self-efficacy in their work.

References

1. Ratanawongsa N, Matta GY, Bohsali FB, Chisolm MS. Reducing Misses and Near Misses Related to Multitasking on the Electronic Health Record: Observational Study and Qualitative Analysis. *JMIR Hum Factors*. 2018;5(1):e4. doi:10.2196/humanfactors.9371
2. Berkhof M, van Rijssen HJ, Schellart AJM, Anema JR, van der Beek AJ. Effective training strategies for teaching communication skills to physicians: an overview of systematic reviews. *Patient Educ Couns.* 2011;84(2):152-162. doi:10.1016/j.pec.2010.06.010
3. Chou, C.L., Cooley, L., (Eds.). (Oct 2017). *Communication Rx: Transforming Healthcare Through Relationship-Centered Communication*. New York, NY: McGraw Hill. Free Chapter download available at www.CommunicationRx.org
4. Chou, Calvin L.; Cooley, Laura; Pearlman, Ellen; and White, Maysel Kemp (2014) "Enhancing patient experience by training local trainers in fundamental communication skills," *Patient Experience Journal*: Vol. 1 : Iss. 2 , Article 8. Available at: http://pxjournal.org/journal/vol1/iss2/8

Appendix

About the Academy of Communication in Healthcare

Mission Statement:

ACH is the professional home for all those who are committed to improving communication and relationships in healthcare.

ACH accomplishes this through:

- Welcoming researchers, educators, clinicians, patients, patient advocates, and all members of the healthcare team to join as active members of the Academy.
- Providing communication skills training for healthcare systems seeking support for clinicians and staff education to improve communication and patient experience.
- Providing opportunities for collaboration, support and personal and professional development.
- Identifying strengths, resources and needs of patients, their family members and healthcare professionals, both as unique individuals and in relationship to one another.
- Developing skills that integrate biological, psychological and social domains.
- Applying existing scholarship from multiple disciplines and developing new knowledge through research.
- Promoting collaborative relationships between clinicians and patients, teachers and learners, and all members of the health care team.
- Incorporating core values of respect, empathy and genuineness in human relationships and the importance of self-awareness in all activities.

Vision Statement:

A health care system where all patients, healthcare professionals, trainees and researchers feel valued, are treated equitably with respect, compassion, understanding, and are actively engaged in healthcare processes and decisions.

About the Authors

Stacy Palmer, CPXP

Senior Vice President
The Beryl Institute

Stacy is a visionary thinker and pragmatic strategist who has been a leader in the expansion of patient experience as a central conversation in healthcare. With a commitment to gather, understand and integrate insights and ideas from The Beryl Institute community, she has helped establish a resource library of proven practices and research sharing how healthcare organizations around the globe are creating positive experiences for patients, family members and caregivers. She also works closely with resource providers offering the latest in patient experience related solutions and services to broaden industry awareness of the tools available to impact overall experience efforts. She has co authored numerous white papers from The Beryl Institute. In addition, she is a regular contributor to the Patient Experience Blog and stays connected to the work on the front lines of care through visits to healthcare organizations, sharing their experience journeys through the On the Road series. Stacy also leads the Institute's event strategy and is primarily accountable for growing its annual Patient Experience conference from a small community gathering to what is now considered the largest independent event bringing together the voices of healthcare professionals across the globe to expand the dialogue on patient experience improvement.

Laura Cooley, PhD

Senior Director of Education and Research
Academy of Communication in Healthcare

Assistant Clinical Professor, Department of Medicine,
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Laura leads strategic efforts to support the ACH mission by collaborating with healthcare leaders to develop and deliver customized communication skills training programs. She has led presentations at many notable U.S. healthcare centers and at national events hosted by organizations such as, The Institute for Healthcare Improvement (IHI), The American Medical Group Association (AMGA), Planetree, The Beryl Institute, and Press Ganey. She is co-editor for the book "*Communication Rx: Transforming Healthcare Through Relationship-Centered Communication*", a practical guide to help healthcare providers and leaders as they aim to improve communication and experiences.

Janella Hudson, PhD

Program Manager of Education and Research
Academy of Communication in Healthcare

Janella contributed to the current publication during her tenure as Program Manager and of Education and Research for The Academy of Communication in Healthcare. Previously, as a Postdoctoral Fellow in Behavioral Oncology at the H. Lee Moffitt Cancer Center & Research Institute, Dr. Hudson conducted research on the interpersonal communication interactions between patients and providers. She also served as Research Coordinator at Wayne State University/Karmanos Cancer Institute, where she focused on interpersonal communication within the context of the Population Studies and Disparities Research Program.

Contributors

We express special thanks to the 112 individuals who shared their experiences, perspectives and insights in the anonymous online survey. Their contributions provided valuable data on the state of current communication efforts and highlighted opportunities for improvement.

In addition, we thank the ten individuals who provided additional detail and reflection through our qualitative interview process:

Kate Kalthoff, CPXP

Patient Experience Specialist, Service Excellence & Healing Arts, Renown Health, Reno NV

Renown Health is Reno's only locally-owned not-for-profit healthcare network. Renown has 35 sites of care, including a Children's Hospital, Institutes for Cancer and Heart and Vascular Health, and is the only trauma center between Salt Lake City and Sacramento.

Katherine is a patient experience specialist and leads the healing arts program at Renown Health. Kate's approach to her work is simple: leave people, places and things better than you found them.

Sarah Fay, MBA

Director of Guest Experience, Southwest General Health Center, Middleburg Heights OH

Southwest General is a private, not-for-profit, 350-bed acute care facility. Founded in 1920, Southwest General is home to nationally recognized physicians with full access to state-of-the-art technology. Southwest General has a deep commitment to providing personalized care and building a healthy future for the patients, families and communities it serves.

Dawn Sidenberg

Manager Patient Experience, Patient Experience & Safety Program, Quality & Performance Portfolio, Hamilton Health Sciences, Hamilton & West Niagara, Ontario, Canada

Hamilton Health Sciences is Ontario's most comprehensive healthcare system with five hospital sites and five specialized facilities in Hamilton and West Niagara. Our 15,000 staff, physicians, researchers and volunteers serve the health needs of approximately 2.3 million residents of Hamilton, Central South and Central West Ontario, from pre-birth to end-of-life. We are both a community hospital as well as a regional centre for an array of acute care services, including: cardiac, stroke, cancer, trauma, burns, neurosciences and pediatrics. As an academic teaching hospital with more than 1,100 beds and an affiliation with McMaster University and Mohawk College, we are committed to providing exemplary health care while advancing excellence in education and health research. Hamilton Health Sciences has earned recognition as one of the world's leading health sciences research organizations.

The Manager of Patient Experience has leadership and managerial responsibilities at both the planning and operational level. The manager is responsible to assist in the development of the tools, processes and resources necessary to support, measure, monitor, and evaluate the Patient Experience; identify, prioritize and action strategies to improve and advance safe, high quality patient and family centered care; provide infrastructure, tools and resources to facilitate the identification, management and prevention of adverse and critical events; and ensure corporate and local level strategies and tools for monitoring and evaluating performance metrics are established.

Jennifer Ball

National Director of Patient Experience; Professional Development, Xanitos, Newton Square, PA

In 2007 Graeme Crothall, founder and CEO, with over 45 years' experience in hospital housekeeping gained knowledge of a cleaning system redesign and underlying technologies. Graeme immediately recognized the value this system would bring to the healthcare industry and formed Xanitos in 2008 by acquiring two small companies; one of which owned the XRO patient room cleaning system. In 2015 Xanitos was awarded a patent on their XRO System for the method of improving air quality and reducing healthcare-associated infections utilizing a cleaning cart with a vacuum cleaning apparatus.

With a degree in Healthcare Management, Jennifer has over 10 years of experience working with Hospitals and support services in hospitals developing and implementing educational and employee appreciation programs, developing initiatives and best practices to increase patient satisfaction. Jennifer is currently the National Director of Patient Experience and Professional Development for Xanitos.

Meredith Masel, PhD, MSW

Oliver Center UTMB, Galveston, TX

Dr. Masel has a long-standing dedication to supporting effective communication among patients, care partners, and providers and leads the Oliver Center for Patient Safety & Quality Healthcare at UTMB. She is a champion for audio recording in healthcare settings, shared decision making, and for training early career providers in patient-centered interpersonal communication.

Texas' first academic health center opened its doors in 1891 and today has three campuses, four health sciences schools, four institutes for advanced study, a research enterprise that includes one of only two national laboratories dedicated to the safe study of infectious threats to human health, a Level 1 Trauma Center and a health system offering a full range of primary and specialized medical services throughout Texas. UTMB is an institution in the University of Texas System and a member of the Texas Medical Center.

Kathy Bourque

Patient Experience Director, Great Plains Health, North Platte, NE

Great Plains Health in North Platte, Nebraska, is a nonprofit, fully accredited, 116-bed regional referral center serving west Nebraska, northern Kansas and northern Colorado. With nearly 100 physicians representing 30 medical specialties, the Great Plains Health system offers advanced medical services, including heart and vascular, cancer, orthopedic services, women's services, and a level III trauma center. The system employs approximately 1,100 employees and has more than 200 volunteers. The range of patient populations served includes neonatal, pediatric, adult, obstetric and geriatric.

Christine M. Cassisi

Director, Patient Experience, UF Health Shands, Sebastian Ferrero Office of Clinical Quality and Patient Safety, Gainesville, FL

UF Health is a comprehensive academic health center located in Gainesville Florida. We admit 150,000 patients per year and treat over 100,000 patients in our Emergency rooms, including a pediatric emergency department. We care for patients from every county in Florida and from nearby states. In December 2017 we opened our newest building The UF Health Heart and Vascular Hospital and The UF Health Neuromedicine Hospital.

As the Director of Patient Experience, Christine leads a team that includes patient advocates, medical interpreters and a senior quality improvement specialist for patient experience. The team is focused on ways to improve everything from wayfinding to clinical communication in partnership with faculty and staff from across UF Health. Using a multidisciplinary approach, UF Health tackled the tough topic of advance directives; their efforts have resulted in a threefold increase in the number of patients admitted with an advance directive on file. UF Health believes the effort to understand and honor patient's wishes is an integral part of improving the patient and family experience.

Christine Salvi, MHA, BSN, RN, CPXP

Director of Patient Experience, Platte Valley Medical Center, Brighton, CO

Platte Valley is a 98-bed community hospital with outpatient medical plazas in Brighton, Fort Lupton, and the Reunion area of Commerce City. Platte Valley is a secular hospital within the SCL Health System. High-level services include a Primary Stroke Center, a Level III Trauma Center, an Accredited Chest Pain Center, a Level II Special Care Nursery, and an Advanced Wound Center with Hyperbarics. Platte Valley's 10 Pillars of Healing are incorporated into every patient experience. They include integrative therapies, human interactions, support networks, healing design, education and information, healthy and delicious meals, healing art therapy, spirituality, healing touch, and healthy communities to help patients recover.

Christine dedicated to person centric care which is evident by her commitment and passion for always going to the source; patients and families. Her 20 years in healthcare leadership from the bedside to the boardroom has supported the implementation of best patient experience process improvements while maintaining a culture of whole person healing which drives the high quality care delivered and experienced by every patient, every day at Platte Valley Medical Center. Christine is registered nurse (BSN) and a certified patient experience professional (CPXP) with a Master's in Healthcare Administration.

Joni J. Johnson, RN, BSN, MHA, CPHQ

Director of Patient Experience and Nursing Administrative Services, Dignity Health, Mercy San Juan Medical Center, Sacramento, CA

Mercy San Juan Medical Center is a 370 bed Level II Trauma Center, serving Northern California and the greater Sacramento California area. Mercy San Juan has 2500 employees providing the following services:

- Five ICU's: Certified Neuroscience, Cardiac, Trauma, Medical, Surgical
- Family Birth Center
- Level III NICU
- Pediatrics
- Trauma, Med/Surg, Neuroscience, Telemetry and General Surgery Acute Care units
- Certified Bariatric Center
- Dignity Health Cancer Institute
- Cardiovascular Intervention/Cardiac Surgery

Joni is a Registered Nurse who holds her Bachelor's in nursing and Master's in Healthcare Administration. Joni has over 25 years of nursing and healthcare experiences, ranging from Acute care, Emergency Services Leadership, Home Health and Hospice, Process Improvement Practitioner, Quality and Risk management as well as her current role as the Director of Patient Experience and Nursing Administration at Mercy San Juan Medical Center. Joni continually engages executive leadership as well as front line team members for ongoing Patient Experience improvements and strategies, ensuring the Patients and families receive the best experience at Mercy San Juan, aligning with the Mission and Values of Dignity Health. "Hello Humankindness"

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